Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

SAN ANTONIO SPINE & REHAB
1313 SE MILITARY DR STE 107
SAN ANTONIO TX 78214

Respondent Name:
LUMBERMENS UNDERWRITING ALLIANCE

MFDR Tracking Number:
M4-11-4560-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 19

MDR Date Received:
AUGUST 8, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services have been preauthorized as medically necessary. Per Rule 133.240(b). For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title…"

Amount in Dispute: $1,764.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant between August 11, 2010 and October 26, 2010. The carrier submits the requestor is not entitled to reimbursement for the services rendered between said time period. The carrier notes that a contested case hearing decision led to findings that the L3-4 and L5-S1 disc pathology was not compensable; the L4-5 disc pathology was compensable. In addition, a benefit dispute agreement from May 2011 indicates the compensable injury does not include any spinal instability. As a result, the fusion surgery performed in March 2010 was not treatment offered for the compensable injury, and the carrier is not responsible for any of the follow-up treatment that may have been offered post-operatively. Since the services underlying the disputed charges were post-operative rehab, the carrier is not responsible for the charges, and no reimbursement is due.

Response Submitted by: Flahive, Ogden & Latson, PO Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 2010 August 23, 2010	CPT Code 99212	$250.00	$0.00
August 11, 2010 through September 20, 2010	CPT Codes 97110, 97140, 97140, G0283	$1,339.56	$0.00
October 26, 2011	CPT Code 99213	$175.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 2, 2010, September 9, 2010, September 20, 2010, October 4, 2010, November 12, 2019, December 2, 2010,December 15, 2010, January 11, 2011, January 24, 2011, February 15, 2011, April 26, 2011

- 080 – Denied per carrier.
- 216 – Based on the findings of a review organization.
- 219 – Based on extent of injury.
- B20 – Srvc partially/fully furnished by another provider.
- 193 – Original payment decision maintained.
- 97A – Provider appeal.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.20?
2. The treatment/services were denied based on an extent of injury. Did final adjudication of the extent issue take place?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted the request for medical fee dispute resolution, including a copy of the Decision and Order of the Contested Case Hearing signed and dated December 16, 2009. Therefore, the requestor has meet the requirements of 28 Texas Administrative Code §133.307.

2. According to the Decision and Order of December 16, 2009, a Benefit Review Conference was held on July 2, 2009 to mediate resolution of the disputed issues; however, the parties were

unable to reach an agreement. A Contested Case Hearing was held on December 14, 2009, The decision of the Hearing Office was that the Claimant's compensable injury of November 21, 2008, extends to include lumbar disc protrusions at L4-5. The Claimant's compensable injury of November 21, 2008, does not extend to include lumbar disc protrusion at L3-4 and L5-S1.

The respondent included, in their response to the request for medical fee dispute resolution, a copy of a Benefit Dispute Agreement, signed and dated May 11, 2011 by both parties, states that the compensable injury does not include spinal instability.

3. Review of the CMS-1500 shows the requestor billed ICD-9 codes 729.1, Unspecified myalgia and myositis; 724.4, Thoracic/lumbosacral neuritis/radiculities; and 847.2, Lumbar sprain and strain. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_	July 20, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.